

KEEPING CURRENT

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The Importance of Maintaining Appropriate Patient Health Records

By Lad Kucis

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Lad Kucis
Partner
416.864.3114
lkucis@grllp.com

Maintaining complete and accurate patient health records is a foundational obligation for all regulated health professionals in Ontario. In addition to verifying what occurred at an appointment and supporting continuity of care, proper recordkeeping is a legal and professional requirement that carries significant regulatory, employment, and financial implications, if neglected.

This article examines the sources of recordkeeping requirements, outlines the obligations of regulated health professionals and identifies the risks associated with failing to meet recordkeeping standards.

Legal and Regulatory Obligations in Ontario

All regulated health professionals in Ontario are legally required to maintain appropriate patient health records. This obligation flows from the following sources:

- *The Regulated Health Professions Act, 1991* (RHPA), which is the statute that governs all health professions in Ontario;
- Profession-specific enabling legislation,

such as *Nursing Act, 1991*, the *Pharmacy Act, 1991*, the *Massage Therapy Act, 1991*, etc.;

- Ontario's health sector privacy statute, the *Personal Health Information Protection Act, 2004* (PHIPA); and
- Standards and guidelines issued by health professions regulatory colleges, which specify:
 - The types of records that must be maintained (i.e. appointment records, health histories, clinical notes, financial records, etc.);
 - Minimum requirements for the content of those records; and
 - Other requirements related to recordkeeping, including retention obligations, making changes to records, and rules that apply when departing a clinic or leaving the profession.

Accuracy, Completeness, and Reliability

Regulatory colleges consistently emphasize that health records must be accurate, complete and

contemporaneous. Records that are incomplete, unclear or not maintained in a timely manner may be deemed non compliant with professional standards.

Health professionals are expected to create records that reliably reflect:

- Whether an appointment occurred;
- The services provided;
- Clinical findings and decision making;
- Patient instructions and follow up; and
- Informed consent or refusal of treatment.

Confidentiality and Secure Record Management

Recordkeeping obligations extend beyond simply preparing patient records. Rather, health professionals must comply with the requirements of PHIPA and ensure that patient records are:

- Stored, maintained, transferred, and disposed of securely; and
- Protected from unauthorized access, loss, or misuse.

In addition, health professionals are required to take the following additional steps, which are also set out in PHIPA:

- Establishing appropriate information practices;
- Ensuring that a privacy statement is in place;
- Limiting access to personal health information on a need to know basis;
- Properly training staff in respect of privacy practices;
- Responding to privacy breaches in a timely and appropriate manner; and

- Responding to requests for access to records of personal health information.

Evidentiary Importance of Clinical Notes

In many legal and regulatory proceedings, the patient health record is treated as the best evidence of what occurred at an appointment.

In certain cases, incomplete or missing clinical notes can make it difficult to prove that an appointment even occurred. This can be particularly problematic when verifying service dates with insurers or defending allegations of fraud or improper billing.

Furthermore, health professionals often rely on their clinical notes to confirm what occurred during an appointment. Where notes are brief or entirely absent, it can be difficult, if not impossible, to accurately recall events or substantiate the practitioner's account. This lack of documentation can significantly weaken a health professional's position in the context of a complaint, legal proceeding, or insurance audit.

Consequences of Inadequate Recordkeeping

A failure to maintain appropriate patient health records can result in serious ramification for a health professional. Some of the key potential consequences include the following:

1. Complaints to Health Professions College

First and foremost, a failure to maintain records can result in a complaint to a health professional's regulatory college. In considering this item, it is important to recognize that regulatory colleges treat inadequate recordkeeping as "professional misconduct". As such, recordkeeping shortcomings can result in any of the following, depending on the severity of the breach:

- A caution;



- A Specified Continuing Education and Remediation Program (SCERP);
- An undertaking outlining steps to be taken to improve recordkeeping; or
- A finding of professional misconduct, following a discipline hearing (which is most likely to occur if there are other forms of misconduct at issue, in addition to recordkeeping).

Furthermore, deficiencies in recordkeeping are a sufficient reason for regulatory college sanction, even if there was no corresponding patient harm. In addition, a regulatory college can start a separate investigation into recordkeeping even where an original complaint/investigation had nothing to do with recordkeeping.

2. Complaints to Information Privacy Commissioner

A health professional who fails to safeguard personal health information or otherwise comply with the requirements of PHIPA may be subject to a complaint to the Information and Privacy Commissioner (IPC), which is the oversight body responsible for administering PHIPA.

The IPC can conduct a formal investigation and may issue orders against the health professional, including to change or implement information practices, improve administrative, technical or physical safeguards, grant access to or correct personal health information, etc. The IPC also possesses the authority to issue administrative monetary penalties for serious or systemic PHIPA breaches.

3. De-Listing by Insurance Companies

Insurers routinely audit patient records to confirm that billed services were in fact provided. Where documentation is inadequate,

it may undermine the credibility of claims and raise broader concerns about a practitioner's administrative, billing and compliance practices.

If an insurer concludes that a billed service was not provided, or that a health professional's documentation and administrative practices fall below expected standards, it may de-list the practitioner. De-listing renders the practitioner's services permanently ineligible for reimbursement by that insurer, which can have serious financial consequences, particularly where a major insurer is involved. It is also imperative to keep in mind that it is extremely challenging to have an insurer reverse a de-listing decision, at any point in time.

Finally, in many cases, insurers will also file a corresponding complaint with the practitioner's regulatory college following de-listing, further compounding the overall impact of the matter.

4. Workplace Consequences

Clinics, hospitals, and other health care facilities frequently establish their own documentation standards and policies. Failure to comply with these requirements may result in serious employment consequences, including disciplinary action, loss of hospital privileges or termination of employment or contract.

Even where the clinical care provided is appropriate, inadequate recordkeeping may be viewed as a significant breach of employer expectations and can be treated as a serious administrative failing in the employment context.

Key Takeaways

The maintenance of complete and accurate patient health records is not discretionary, but is rather a fundamental legal and professional obligation. Sound recordkeeping practices serve multiple critical purposes, including:

- Enabling the optimal delivery of patient care;
- Assisting other members of the circle of care and future care providers;
- Demonstrating compliance with regulatory and professional requirements; and
- Mitigating legal risk.

Health professionals are strongly encouraged to regularly review the recordkeeping standards of their regulatory college to ensure that their documentation practices are consistent with applicable legal and professional requirements.

About the Author

Lad Kucis is certified by the Law Society of Ontario as a specialist in health law and provides advice and representation to regulated health professionals in respect of all types of regulatory matters, including complaint and disciplinary matters before their regulatory colleges, and complaint reviews before the Health Professions Appeal and Review Board.

He can be contacted at 416.864.3114 or at lkucis@grllp.com.

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